

## Department of Pharmaceutical Services

## Application for Nutrition Support Pharmacy Fellowship

**APPLICATION INSTRUCTIONS**

All applicants do not need to be enrolled in the ASHP marching program. This application is due by midnight on **December 31st**. The application will be considered complete once all required information is received. Submit all of the following:

1. **Completed Application**

* Even if some information may be contained on your CV, please fully answer each question

1. **Current Curriculum Vitae**

* Include schools and universities attended, degrees conferred or anticipated, employment history, honors and awards, rotation experiences, research or teaching experiences, extracurricular activities, and other pertinent information

1. **Letter of Intent**

* Describe the reasons for applying to this fellowship program and what you expect to gain from such a program, as well as short and long-term goals for your career in pharmacy

1. **Three (3) completed Letters of Recommendation**

* Please send the electronic form to the individuals providing recommendations after completing the top portion of the form. Electronic submission should be from the recommender’s institutional or business email address to verify authenticity.
* At least 1 of the 3 recommendations must be from an APPE preceptor or residency preceptor

1. **Transcripts**

* For all academic coursework in pharmacy
* You may submit a transcript that is missing the most recent semester’s coursework

**PLEASE SUBMIT APPLICATION MATERIALS AS FOLLOW:**

**Electronic Submission: Hard Copy Submissions:**

(Transcript only)

\* Email to: [vivian.zhao@emoryhealthcare.org](mailto:vivian.zhao@emoryhealthcare.org) \* Address to

\* Attached all documents to emails (application, Vivian Zhao

CV, letter of intent) Nutrition Support Pharmacy Fellowship Director

\* For subject line: NSFP and your name Department of Pharmaceutical Services

\* For recommendations, request recommender Emory University Hospital, Room EG22

attach the form to an email and send it from institutional 1364 Clifton Road, N.E.

or business email (i.e., not Gmail, Hotmail, etc.) Atlanta, Georgia 30322

**NOTE: Your application will only be considered if all required information is received.**

**Applicant Name** (First, MI, Last name)**:**

1. **Contact Information:**

|  |  |  |
| --- | --- | --- |
| Correspondence Address: | | |
| City: | State: | Zip Code: |
| Email Address: | | Preferred Telephone: |

2. **Personal Information:**

a. Are you a citizen of the United States? Yes  No

If other, please list your country of citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Do you have a visa permitting you to work in the U.S. through the end of the fellowship?

Yes  No

3. **General Information:**

a. Language(s) other than English (including American Sign Language) are you FLUENT enough to

Interview patients: Yes  No If yes, what language(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Have you ever been convicted of a felony: Yes  No If yes, briefly describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Non-curriculum-based internship hours (estimated): ­­­­\_\_\_\_\_\_\_ hours

d. Curriculum-based internship hours (estimated): \_\_\_\_\_\_\_\_\_\_ hours

3. **Degree(s) Earned:**

|  |  |  |  |
| --- | --- | --- | --- |
| Degree | College/University | Start Date | End/Anticipated End Date |
| Pharm.D. |  |  |  |
| BS Pharm |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Other: |  |  |  |

4. **Prior Residency / Fellowship Experience**

Have you completed or are you currently completing a pharmacy residency/fellowship in the U.S.?

Yes  No (If you answer “no,” please skip to question 5.)

|  |  |  |  |
| --- | --- | --- | --- |
| Training | Where (City/State) | Institution | Specialized Area |
| PGY1 residency |  |  |  |
| PGY2 residency |  |  |  |
| Fellowship |  |  |  |

5. **Licensure Information**

|  |  |  |  |
| --- | --- | --- | --- |
| License State | License Number | Type | Expiration Date |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

6. **Recommendations**

List at least 3, no more than 4, individuals who will be completing recommendations for you

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | TITLE | PHONE/EMAIL | RELATIONSHIP |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

7. Do you have any pharmacy-related work experience? Yes  No

If **yes**, please indicate below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Position Title | Hours per week | Employment Type | |
|  |  |  | Part Time | Full Time |
| Community |  |  | throughout the year (Even while in school)  when not in school (summer, school breaks, & holidays) | throughout the year (Even while in school)  when not in school (summer, school breaks, & holidays) |
| Hospital |  |  | throughout the year (Even while in school)  when not in school (summer, school breaks, & holidays) | throughout the year (Even while in school)  when not in school (summer, school breaks, & holidays) |
| Other: |  |  | throughout the year (Even while in school)  when not in school (summer, school breaks, & holidays) | throughout the year (Even while in school)  when not in school (summer, school breaks, & holidays) |

*Duties Performed*:  Order Entry  Patient Counseling Order Clarification

Ordering/Purchasing IV Compounding Fill Rx’s Kinetics

Chemo Compounding  NST Compounding Medication History Cart Fill

Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Check all **in-patient rotations** you will complete before the beginning of the fellowship.

Internal Medicine Critical Care Psychiatry Peds/Neonatology Drug Info

Family Medicine Pharmacokinetics Trauma/ER Neurosciences Cardiology

General Surgery Heme-/Oncology Geriatrics GI Medicine BMT

Endocrinology Nutrition Support Pulmonary Infectious Disease

Solid Organ Transplant Others(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Check all **outpatient rotations** you will complete before the beginning of the fellowship.

Family Medicine Hypertension AIDS/HIV Seizure/Anticonvulsant

Internal Medicine Diabetes Lipid Anticoagulation

Others(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Have you had any pharmacy-related teaching experience? Yes  No

If **yes**, briefly describe the following:

11. Have you been involved with any pharmacy-related project or research? Yes  No

If **yes**, briefly describe the following:

12. Describe your responsibilities on your clinically oriented rotations to date. Please list and describe the rotation, including rounding, team members, patient load, and specific activities and responsibilities.

13. Describe a situation that involved conflict and how you worked to resolve this issue.

14. To the best of your knowledge, what is your current GPA? \_\_\_\_\_\_\_\_\_\_\_\_

15. **Application Certification**

By typing below, I certify that all of the information submitted in this application is complete and correct to the best of my knowledge and belief. I understand that any significant misstatement in, or omission from, this application may be cause for denial of selection as a resident or dismissal from a residency position. I authorize the fellowship site to consult with persons and institutions I have been associated with who may have information on my professional competence, character, and ethical qualifications now or in the future. I release all fellowship staff from liability for acts performed in good faith and without malice in evaluating my application, credentials, and qualifications. I also release from liability all individuals and organizations who provide information to the fellowship site in good faith and without malice concerning my professional competence, ethics, character, and other qualifications now or in the future.

I grant Emory Hospitals permission, if necessary, to request additional information from previous schools, employers, and preceptors concerning my academic record and professional ability.

I understand and agree that, as an applicant for the pharmacy fellowship program, I have the burden of producing adequate information to evaluate my professional competence, character, ethics, and other qualifications and resolve any doubts about such qualifications.

I hereby agree that personally identifiable information about me, including but not limited to my academic and professional qualification, performance, and character, in whatever form maintained, may be provided to any fellowship training site to which I have applied.

Electronic Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please type)

Signature Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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